PRINTED: 12/12/2019 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_\_ C B. WING IL6010078 10/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 16000 SOUTH WABASH **PRAIRIE OASIS** SOUTH HOLLAND, IL 60473 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 000 Initial Comments S 000 COMPLAINT INVESTIGATION 1997149/IL116151 S9999 Final Observations S9999 Statement of Licensure Violation 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Attachment A Section 300,1010 Medical Care Policies

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not

**Electronically Signed** 

TITLE

Statement of Licensure Violations

(X6) DATE 10/21/19

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_\_\_ B. WING IL6010078 10/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 16000 SOUTH WABASH **PRAIRIE OASIS** SOUTH HOLLAND, IL 60473 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 1 S9999 limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ IL6010078 10/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 16000 SOUTH WABASH **PRAIRIE OASIS** SOUTH HOLLAND, IL 60473 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 2 S9999 These Regulations were not met as evidence by: Based upon record review and interview the facility failed to assess pain level, failed to address resident change in condition, and failed to provide timely care/services for one of six residents (R1) in the sample. These failures resulted in R1 having pain that was not treated and a delay in treatment. R1's x-ray revealed fracture of distal tibia and fibula which required surgical intervention. Findings include; The (4/14) change in condition policy states; the Nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgment requires immediate medical intervention. The (9/14) incident/accident reports policy & procedure states; an incident report will be completed for all accidental/incidental unusual occurrences. R1's progress notes state; (9/23/19) 4:50pm, Resident reaching for CNA (Certified Nursing Assistant) when left leg is moved. Resident nod head when writer asked if she was in pain and she pointed to left leg [Physical assessment and/or pain level are not documented]. (9/24/19) 7:33am, Resident made gestures of pain to left leg. When examined observed darkened circular area to left lower anterior leg. Tender to touch upon palpation [Pain level is not documented]. Slight edema is present. Doctor paged at this time. There is no documentation that physician contact was made and/or incident report initiated]. 4:45pm, upon making rounds CNA asked writer

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to come look at resident left leg. Assessment

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |                               | (X3) DATE SURVEY<br>COMPLETED  |        |
|---|---|---|--|-------------------------------|--|--------|
|   |   | 11 00400=0  | B. WING                                  |                               |  |        |
|   |   | IL6010078   | B. W114G                                 |                               | 10/0   | 3/2019 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  PRAIRIE OASIS  16000 SOUTH WABASH |   |   |  |                               |  |        |
| SOUTH HOLLAND, IL 60473   |   |   |  |                               |  |        |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFIX<br>TAG                      | (EACH CORRECTIVE ACTION SHOUL | PROVIDER'S PLAN OF CORRECTION (X5) EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE DEFICIENCY)  (X5)  COMPLETE DATE |        |
| S9999   | Continued From page 3   |   | \$9999                                   |                               |  |        |
|   | green in color with supon palpation. Do assessment gave o X-ray done results a  | be cool to touch, yellowish swelling. Resident whimper ctor present during rders for STAT x-ray. 6:13pm, pending. (9/25/19) 1:39am, ed fracture of distal tibia and   |  |                               |  |        |
|   | Physician was "pag<br>the progress note) '<br>replied "That was a   | om, Surveyor inquired if the ed" at 7:33am (as stated in V9 (Licensed Practical Nurse) ctually a mistake with timing it I. I evaluated her at that time."   |  |                               |  |        |
|   | R1's (9/24/19) injury<br>Nurse) stated "About<br>come and look at his<br>was aware of R1's of<br>V10 responded "No      | om, surveyor inquired about y V10 (Licensed Practical ut 4:30pm, the CNA told me to er. Surveyor inquired if she change in condition at 3:00am, o maam. I did not get report in nurse takes the report she of to me." |  |                               |  |        |
|   | R1's injury V11 (Rel<br>I was doing rounds,<br>report to the dayshi   | om, surveyor inquired about<br>storative Nurse) stated "When<br>the nurse (V9) was giving<br>ft Nurse (V12/Licensed<br>d said her leg was red."   |  |                               |  |        |
|   | stated "(V9) said shon 9/24/19. I know from the doctor bed calling and couldn't the dayshift Nurse (change in condition |   |  |                               |  |        |
|   | documentation of e  | sessment policy states;<br>ach pain assessment will be<br>n assessment form, in the   |  |                               |  |        |

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ B. WING IL6010078 10/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 16000 SOUTH WABASH **PRAIRIE OASIS** SOUTH HOLLAND, IL 60473 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 nurses notes or on the MAR (Medication Administration Record). R1's (September 2019) MAR includes; unscheduled orders; pain assessment every shift. Record actual score 0-10. [There are no pain assessments documented]. Acetaminophen was administered for pain on 9/23 at 4:50pm, and 9/24/19 at 4:59pm however pain assessments are not inclusive. On 10/3/19 at 9:09am, V1 (Administrator) affirmed the facility does not have a policy for STAT turnaround time. On 10/3/19 at 9:41am, V2 stated "For our STAT x-rays and labs we usually have procedures done and results within 4-5 hours." On 10/3/19 at 10:59am surveyor inquired about R1's status V14 (Hospital/Registered Nurse) stated "On 9/25/19 at 5:23am she received Toradol (Anti-inflammatory) 60mg (milligrams) IM (Intramuscular) and Fentanyl (Opiod pain reliever used to treat severe pain) 50mg IM for pain. She had an ORIF (Open Reduction Internal Fixation) 2 days ago. On 10/3/19 at 11:19am, surveyor inquired about R1's (9/24/19) injury V15 (Physician) stated I came and saw her, the bones were unstable. Surveyor inquired what "unstable" means V15 responded "That means there's probably a fracture." Surveyor inquired about R1's (9/24/19) pain level at that time V15 stated "Pain rating it's difficult to say she had a stroke. She was kind of a making faces, grimaces. Surveyor inquired about the potential harm to R1 if pain medication was not administered as warranted V15 stated

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"There's patient pain."

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